MEDI-CAL UPDATE Part 2
Billing and Policy
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Allied Health • Orthotics and Prosthetics

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Contents

Therapeutic Diabetic Shoes and Inserts: New Benefit

Effective for dates of service on or after April 1, 2006, therapeutic diabetic shoes and inserts are a new benefit for recipients with a diagnosis of diabetes mellitus. HCPCS codes for the new benefits are as follows:

HCPCS Code	Description
A5500	Fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe
A5501	Fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe
A5503	Modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe
A5504	Modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe
A5505	Modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe
A5506	Modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe
A5507	Not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe
A5512	Multiple density insert, direct formed, molded to foot after external heat source of 230 degree Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each
A5513	Multi-density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each

Please see **Therapeutic Shoes**, *page 2*

Therapeutic Shoes *(continued)*

Prior Authorization
These services require prior authorization. With the *Treatment Authorization Request* (TAR), providers must submit a clinician-signed *Clinician Certification of Medical Necessity for Therapeutic Shoes* form to certify that the recipient has one or more of the following conditions:

- Foot ulcers
- Previous amputation of the contralateral foot, or part of either foot due to microvascular disease secondary to diabetes
- History of previous foot ulceration of either foot
- Peripheral neuropathy with evidence of callous formation of either foot
- Foot deformity of either foot, that is, rocker bottom foot or Charcot foot
- Documentation of compromised vascular disease in either foot
- Positive monofilament examination indicating diabetic neuropathy

The *Clinician Certification of Medical Necessity for Therapeutic Shoes* form has been developed and is included in this bulletin to help providers meet prior authorization documentation requirements.

The following additional information is required on the *Clinician Certification of Medical Necessity for Therapeutic Shoes* form, as appropriate, for prior authorization of codes A5501 and A5513:

- Diabetes mellitus with neurological manifestations
- Diabetes mellitus with peripheral circulatory disorders
- Diabetes mellitus with other specified disorders (amputations, significant deformities and or pre-ulceration)

Billing Instructions/Limitations
Only orthotists and prosthetists may bill for these services. Claims for orthotic and prosthetic appliances require modifier -LT (left side) and/or -RT (right side), as appropriate.

Codes A5500 and A5501 have a frequency restriction of one pair per calendar year. Codes A5512 and A5513 are restricted to three pairs per calendar year when billed in conjunction with either code A5500 or A5501.

This information is reflected on manual replacement pages ortho 11 (Part 2), the new Clinician Certification of Medical Necessity for Therapeutic Shoes form (Part 2) and ortho cd1 1 (Part 2).

Reciprocating Gait Orthoses Documentation Requirements

Providers are reminded that Reciprocating Gait Orthoses (RGOs) are reimbursable as a Medi-Cal benefit when billed with prior authorization and proof that they are medically necessary for recipients 2 years of age and older with the following conditions:

- Thoracic or upper lumbar spine lesions with spasticity;
- Contractures of all levels of the lower extremity(ies) as long as the joint(s) is (are) flexible to manipulation.

Orthotic devices are Medi-Cal benefits when the equipment is reasonable and necessary for the treatment of an illness or injury, or to improve the function of a malformed body member. Orthoses must meet all applicable Medi-Cal statutory requirements as set forth in *California Code of Regulations* (CCR), Title 22, Sections 51321 and 51521.

Please see **Orthoses**, *page 3*

Orthoses *(continued)*

The following documentation must be included when submitting a *Treatment Authorization Request* (TAR) for RGOs (HCPCS codes L2010, L2020, L2035 – L2037, L2039, L2510, L2520, L2525, L2627 and L2628):

- A primary physician must document that the recipient has cardiopulmonary integrity.
- An orthopedist or Physical Medicine and Rehabilitation Physician (PMR) must document that no other orthoses would be helpful.
- A neurologist must document that the spinal cord injury level is above L3.
- An independent physical therapist, other than the one in the orthotic/rehab unit, must document that the recipient does not have contractures and/or muscle atrophy that would preclude use of the RGO.
- X-rays of the spine must document that there is stability of the spine.
- X-rays of the spine, hips and knees must document a lack of advanced osteoporosis and fractures.
- One of the following ICD-9 diagnosis codes must be included on the TAR:
  - 344.1 (paraplegia);
  - 741.92 (spina bifida, without mention of hydrocephalus, dorsal [thoracic] region); or
  - 741.93 (spina bifida, without mention of hydrocephalus, lumbar region)

In addition to the above documentation, the following documentation is required when a TAR for RGOs is submitted for recipients 21 years of age and older:

- Plantigrade feet
- Knees and hips must not have greater than 10 degrees of contracture
- The hips must be flexible without rigidity or spasticity
- Good upper extremity strength
- Motivated, has realistic goals and expectations, and has a support system

Contraindications to RGOs include the following:

- Severe irreducible contractures that prevent establishing normal alignment
- Spasticity or other voluntary muscle activity that prevents free and coordinated mobility
- Obesity (BMI > 32)
- Poor upper extremity strength
- Advanced osteoporosis
- Fractures or a history of fractures
- History of not following treatment plans (noncompliance)
- Pressure sores in areas that would be in contact with the orthosis

The treating therapist and/or orthotist must submit a report to the primary care physician at six months of use to document the recipient's success or failure with the RGO.

The updated information is reflected on manual replacement page ortho 12 (Part 2).

Negative Pressure Wound Therapy Electrical Pump Rate Change

Effective for dates of service on or after April 1, 2006, reimbursement for the rental of Negative Pressure Wound Therapy (NPWT) electrical pumps (HCPCS code E2402) is changed from a monthly to a daily rate. The new daily rate is $45.77. NPWT items require prior authorization. *This information is reflected on manual replacement page dura cd 24 (Part 2).*

End Stage Renal Disease Pilot Project

Under a four-year pilot project, recipients with End Stage Renal Disease (ESRD) may enroll in "VillageHealth operated by SCAN Health Plan" (VillageHealth), a Medicare Health Maintenance Organization (HMO). Effective for dates of service on or after January 1, 2006, VillageHealth serves recipients in select ZIP codes in San Bernardino and Riverside counties. Ordinarily, recipients with ESRD would be excluded from enrollment in a Medicare HMO.

VillageHealth is partnering with DaVita and other providers in this endeavor, as follows:

- VillageHealth (an ESRD Specialty Health Plan/California Medical Services Demonstration Project) is the primary payer.
- DaVita renders the dialysis services.
- Other providers may render additional medical services.

Provider Manual
Policy about this pilot project has been added to the MCP: Special Projects section of the Part 1 Medi-Cal provider manual.

Billing
Providers bill for services to VillageHealth members as follows:

- Plan-covered services to VillageHealth
- Copayments, coinsurance or deductibles for plan-covered services to Medi-Cal (similar to crossover claims)
- Services denied or not covered by VillageHealth, to Medi-Cal as standard fee-for-service claims

Copayments, Coinsurance and Deductibles
Claims for copayments, coinsurance or deductibles must be submitted as paper claims. Instructions for submitting paper claims closely parallel instructions for billing Medicare/Medi-Cal hard copy crossover claims, except for the few additional requirements noted below. Therefore, billers should refer to the "Hardcopy Submission Requirements of Medicare-Approved Services" in the Part 2 manual.

In their interpretation of the manual, billers should consider "VillageHealth" the same as "Medicare." For example, in the *Medicare/Medi-Cal Crossover Claims: HCFA 1500* section, under the "Part B Services Billed to Part B Carriers" heading, the reference to "Medicare approved service" would also be interpreted as "VillageHealth approved service."

In addition, claims for copayments, insurance or deductibles treated like crossovers must be billed to Medi-Cal with the same national procedure codes and modifiers billed to VillageHealth and include the following:

- A copy of the *Remittance Advice* (RA) received from VillageHealth. The RA must state "SCAN ESRD PILOT" in the *Remarks* section at the bottom left and include the address and telephone number for VillageHealth in the upper right corner.
- VillageHealth AEVS (Automated Eligibility Verification System) carrier code "S323" in the *Insurance Plan Name or Program Name* field (Box 11c) on the *HCFA 1500.*

Electronic billing may eventually be an option.

This information is reflected on manual replacement pages mcp spec 7 and 8 (Part 1) and medicare 3 (Part 1).

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	*Contents for Orthotics and Prosthetics Billing and Policy* iii/iv *
Remove and replace:	dura cd 9/10 *, 23/24
Remove: Insert:	ortho 11/12 ortho 11 thru 15
Insert after the end of the *Orthotic and Prosthetic Appliances* section:	*Clinician Certification of Medical Necessity for Therapeutic Shoes* form
Remove: Insert:	ortho cd1 1 thru 26 ortho cd1 1 thru 31

* Pages updated due to ongoing provider manual revisions.